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INTRODUCTION

The Health and Human Services Agency is responsible for management of the public mental health system for the County of San Diego. The provider network includes County operated programs and contract operated programs, which are known as organizational providers. The provider network also includes private practitioners such as psychiatrists and psychologists, which are known as individual fee for service (FFS) providers. Each of these provider groups is responsible for specific functions related to determining client financial eligibility, billing and collections. This handbook provides standardized procedures for organizational providers, who may be County or contract, operated programs. While many of the functions are the same for County and contract operated programs, contract programs have some additional responsibilities as United Behavioral Health (UBH) performs certain functions for County operated programs.

UBH/San Diego

UBH/San Diego provides the following financial management activities for the mental health system:

- Maintains the client and billing data Management Information System (MIS) InSyst;
- Coordinates billing and payment activities;
- Facilitates comprehensive reporting and error correction processes;
- Provides training and technical assistance;
- Monitors providers' administrative compliance with policies and procedures; and

UBH/San Diego provides the following additional functions for County operated programs:

- Medicare, insurance and client billing, and collections;
- Correction of errors including Medi-Cal Error Correction Reports (ECRs)

Together the County and UBH have developed the financial procedures detailed in this handbook, considered a cornerstone of the collaborative revenue enhancement efforts, with a focus on helping your program staff understand, correctly utilize and benefit from the information management system—ultimately allowing you to better serve your clients.

This handbook is not intended to replace the InSyst Users Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

For general information, United Behavioral Health, San Diego, can be reached at (619) 641-6800.

USING THE InSyst SYSTEM

Data entry for all client registration, episode, and service activities is done directly online using the InSyst System managed by UBH. InSyst is a fully integrated network system that provides complete client tracking and billing functionality to authorized users, 24-hours a day, including:

- An On-line Client Locator
- Client Registration
- Assessment of the UMDAP (Uniform Method for Determining Ability to Pay)
- Online Medi-Cal Eligibility Verification
- Episode Opening and Closing Processes
- Service Recording and Historical Inquiry
- Service and Financial Reporting

The system allows for on-line financial assessments. It will perform Medi-Cal, Medicare, third party insurance, and client billing functions as well as accounts receivable and electronic payments processing. The system will also perform various validations to support accurate data entry.

Managing Client Information

Organizational providers register clients, determine financial eligibility and record episode and service activities through the InSyst system. For more detailed instructions on using the system, please refer to the InSyst User Manual.

Program Set-Up

A Reporting Unit Setup/Update Form must be submitted to UBH in order to define the program parameters correctly in InSyst. The form must be completed accurately and in its entirety for each reporting unit. It is also important that UBH be provided with any changes in the program's profile (e.g., address, services provided, billing rates, etc), at least 30 days prior to implementing the change, to ensure that the necessary system updates can be completed in a timely manner.

User Account Set-Up

UBH and San Diego County Health and Human Services Agency's Information Systems (HHSA IS) Department coordinate access to San Diego County's computer systems. If program staff needs access to InSyst (the Mental Health Client database), an authorization form for the County (to establish a VAX account) and for UBH (to establish the InSyst User account) must be completed. Both forms can be obtained by contacting the UBH MIS Customer Service Desk at (619) 641-6928. UBH will accept both forms for processing.

Adding or Changing Staff Information

All staff that render direct or indirect client services must have a Staff ID Number in the InSyst System in order to capture the services they provide. To obtain a staff number for a new staff member, update an existing staff member's information (e.g., new licensure), or delete a terminated staff member, a UBH New Staff/Provider Assignment Form must be completed. When adding a new clinical staff member, it is critical that information including the staff members' licensure, license number, Medicare Unique Provider Identification Number (UPIN), and Medicare Provider Identification Number (PIN) be provided to ensure accurate and appropriate claiming for reimbursement. A copy of this form can be found in the Forms section (page 36) of this handbook.

Connecting to the System

Most County operated sites and some large contract provider sites are connected to the UBH systems via dedicated phone lines. Many sites, however, must dial into the system via modem. New providers should contact the UBH Customer Service Desk at (619) 641-6928 to determine their best dial-in number.

Security and Confidentiality

The UBH MIS and the SDMHS Client Database must be protected from unauthorized use. Only users with a business need to know, who have signed UBH Confidentiality Statements, should be permitted to access the database. All information contained in the database is confidential in accordance with California Welfare and Institutions Code 5328. Sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. All terminals and computer screens should be protected from the view of unauthorized persons. Reports with confidential client information should be stored in a secure place and properly destroyed when no longer needed.

UBH user authorization forms include a confidentiality statement that must be signed by the user and the Program Director.

REGISTERING A NEW CLIENT

Each client's identity must be established in the system prior to entering services. If the client cannot be located using the Client Locator in the InSyst system, the client will need to be registered into the system. Once the Registration process is complete, the system will assign a unique number to the client.

Client Registration Form

The client's information may be entered into InSyst while the client is present, or a hardcopy of the InSyst Client Registration Form can be completed and entered into InSyst at a more convenient time. A copy of the Client Registration Form can be found in the Forms section (page 39) of this handbook.

To assist in ensuring that information is entered accurately, the form is divided into three separate sections to resemble the three separate screens used to capture client information in InSyst:

1. The Registration screen: used to collect general demographic data.
2. The Address screen: used to collect client address information.
3. The Significant Other screen: used to collect data on the client's significant other/emergency contact information, primary clinician or care coordinator.

In addition to using the form to record initial registration information, it can also be used to update existing information. If a hardcopy of the form is completed, it may be filed in the client's file for future reference.

Client registration should occur during the first visit to a program. If it is not feasible to complete the registration prior to or during the first visit, registration should occur no later than the next business day from the first day of service.

TAKE NOTE!

The most critical information you will need to enter correctly during initial registration is the client's:

- Name
- Birth Date
- Social Security Number

Using the Client Registration Screens

To access the Client Registration screens, select "Register" from the Client Maintenance Menu in InSyst. Enter the information into the appropriate fields on the screen.

The most critical information that must be accurately entered during the initial online registration is the client's ***name, birth date, and Social Security Number***. It is helpful to ask the client for a piece of identification that contains this information to verify its accuracy. Obtaining identification also ensures fictitious data is not being provided. If identification is obtained a photocopy should be filed in the client's medical record. *Once this information has been verified in the system, only the County Medical Records Department can modify it.* A Change of Information Form to modify this data is included on page 45 in the Forms section of this handbook. All other information in the client registration can be modified directly online at any time.

Once all of the required data has been entered, the system will prompt the user to verify the information and correct any invalid fields. Once the registration is complete and verified, the data is saved in the system, and a client number is displayed.

For detailed instructions on completing the InSyst client registration forms, or updating demographic information, please refer to the InSyst Users Manual.

EPISODE OPENING/CLOSING, AND RECORDING SERVICES

Opening the Episode

A client episode is the period of treatment from admission through discharge. Before service data for a client can be entered, an episode in the InSyst must be opened through the Episode Maintenance screens. In order to open an episode, a valid client and Reporting Unit number must be entered. Episodes should be opened no later than one business day after the first service.

The Opening date is a critical field. This information is reported to the State, and used in determining the Effective date of the client's UMDAP Liability period. For detailed instructions on opening an episode in InSyst, please refer to the InSyst Users Manual.

Diagnostic Information

Diagnostic data should be provided by the clinical staff to the data entry staff in the appropriate DSM IV/ICD 9 formats. InSyst will accept any valid DSM IV codes for the appropriate Axis'.

Diagnostic information for five Axes' will also be required. On Axis I if more than one diagnosis is present, primary and secondary diagnosis must be specified. Axis II & III is optional, and is in ICD 9-code format. Axis IV is required, but only one value can be specified. The Axis V and past Axis V fields are for assessments of the client's current and past functioning using the Spitzer GAF Scale.

If the client's primary diagnosis is not determined (DSM IV V71.09) or deferred (DSM IV 799.9) at the time the episode is opened, program staff is responsible for updating the diagnostic information fields in InSyst when the diagnosis is determined. This information is critical to ensure InSyst data integrity and appropriate third party payor claiming.

Clinician ID Numbers

Key data fields that must be entered correctly include the Clinician and Physician ID fields. The client's primary clinician/care coordinator and treating physician are captured in these fields. All care coordinators/clinicians should have a Staff ID number assigned to them. The use of generic Staff ID's is not permitted. If a care coordinator/clinician is not listed in the InSyst system, submit a request form to UBH. A copy of the New Staff/Provider Assignment requisition form can be found in the Forms section (page 36) of this handbook.
All of the clinical reports sort by the Clinician ID field (Staff Caseload reports). If this field or the Physician ID field is left blank the accuracy of claims and reports will be affected.

TAKE NOTE!

If the Clinician and/or Physician ID fields are left blank or filled in with invalid ID numbers, claims will be denied.

Closing an Episode

The closing date for each episode of treatment provided in a Reporting Unit must be captured using the Episode Closing screen. Services may only be entered if the dates of service begin with the Episode Opening and end with the Episode Closing date. It is important to ensure that the Episode Opening and Closing dates are accurate. For detailed instructions on closing an episode in InSyst, please refer to the InSyst Users Manual. Episodes should be closed upon termination of treatment.

Service Entry

Clinicians are required to provide medically necessary services to clients and maintaining accurate documentation standards in the client's medical record. Medi-Cal reimbursement criteria for Specialty Mental Health Services are set forth in Title 9. All services should be entered within one business day from the date of service. Case Management Program services should be entered within two business days from the date of service. At the end of each month, each program has five business days to ensure all services for the prior month have been entered. However, to enter services after the five-business day cut-off period, a late entry request must be made to the UBH Customer Service Desk at (619) 641-6928 to receive InSyst system authorization.

TAKE NOTE!

Only the Staff ID of the person actually rendering the service can be used when capturing data. The use of a Staff ID other than the person rendering the service can be considered fraudulent by third party payors.

Inpatient Services

Inpatient services rendered in County operated programs are entered directly into InSyst. All services should be entered in InSyst within one business day from the date of service.

Outpatient Services

All outpatient services rendered in County operated and Contractor operated programs are entered in the InSyst system. This allows UBH to provide required State Reporting, and Medi-Cal claiming. For County operated programs, this also allows UBH to process all third party claiming as well. All services should be entered in InSyst within one business day from the date of service.

Recording Direct Services

InSyst allows direct service data entry in a number of ways:

1. *Single Service Entry* (for entry of a single service rendered to a specific client)
2. *Multiple Service Entry* (for repetitive data entry of up to 20 service lines)
3. *Daily Service Entry* (for inpatient, day treatment and 24 hour programs)

The following fields are required for entering service data in either the Single or Multiple service entry screens:

- Reporting Unit
- Client Number
- Service Date
- Procedure
- Staff
- Staff Duration
- Number in Group
- Location

Optional fields include Co-Staff, and Co-Staff Duration. Co-Staff is used when more than one clinician or waivered staff member actively participate in rendering a service. This is most common in Group Therapy services.

The most frequent errors in recording services occur in the following situations:

- *The date of service* must be the same as, or after, the Episode Opening date, or the same as, or less than, the Episode Closing date, for the specified Reporting Unit.
- A *valid Clinician ID* must be entered in the staff fields. Generic Staff ID's should not be used. If the program utilizes interns, temporary, or per diem staff, a Staff ID form to add the staff member to InSyst must be completed and submitted to UBH.
- *Duration of time is in hours: minutes.* This is especially important when recording data for Group services. The Staff duration for group is Preparation time, Group time, and Charting time. Do not calculate the amount of time per client, the system will calculate this based on the Number of Staff, multiplied by the duration, divided by the Number in the Group.
- *Number in Group will default to 1.* This only needs to be changed if recording Group services. When recording Group services this should reflect how many clients actually attended on the date specified (not how many should have attended).
- *Location*. The system default is code 1 "Office". This is an extremely critical field for claiming and State reporting requirements. It indicates where the service physically occurred. Currently there are 9 valid codes that can be entered here, so please ensure the accuracy of this field before confirming the service data. Additional location codes are listed in Appendix E of the InSyst Users Manual.

TAKE NOTE!

Do not calculate the amount of Group time per client. The InSyst system will calculate this based on the information entered.

The *Multiple Service Entry* screen makes it easy to enter repetitive data (i.e., enter a number of services for one client or one staff person, or enter one type of service for a day, or record Group services). It allows the creation of user-defined defaults that populate the repetitive data fields automatically. When using this screen please remember to enter the letter "W" at the end of each line of service data to be saved. Please refer to the InSyst Users Manual for detailed instructions on using the service entry screens.

Information can be updated through the *Service Maintenance* screen, including staff, duration, and location within seven days from the date of entry. Supervisor authorization is required to change the service date and procedure code. The client, reporting unit number, or service cost cannot be modified. If that information is not correct, the service data must be deleted and re-entered with the appropriate information.

TAKE NOTE!

There is only a seven (7)-calendar day window from the date of entry in which to correct service data that has been saved in the system.

The *Daily Screen* is used to capture Inpatient, Day Treatment, or Crisis Residential Program services. When the Date of Service and the Reporting Unit Number is entered, the system searches for all clients with an open episode as of the service date specified. The system will automatically populate the procedure code field. The user is responsible for validating the information displayed. This particular service entry screen does not allow for Late data entry, therefore services that have not been entered by the cutoff date (usually the 5th working day of the month), must be entered via the Single or Multiple service entry screens.

Recording Indirect/MAA Services

Senate Bill 910 enabled California local governing agencies to request federal reimbursement for certain Medi-Cal Administrative costs, effective July 1, 1992. This reimbursement process later became known as Medi-Cal Administrative Claiming (MAC). Effective 1995 this program was renamed to Medi-Cal Administrative Activities (MAA). The activities reimbursable under MAA include Medi-Cal and Mental Health Outreach, Screening and assisting with the application for Medi-Cal, Intervening in a crisis situation by referring to mental health services for non-open cases, Case Management of non-opened cases and Training for MAA related activities. Program planning and Contract Administration, can be claimed by County staff only.

In order to claim MAA, the Centers for Medi-Cal and Medicare (CMS) requires that each participating mental health claiming unit submit a comprehensive mental health MAA claiming plan as specified in the California Department of Mental health instruction manual. Prior to submitting claims for reimbursement the claim plan must be approved by the State Department of Mental Health and CMS.

In order to ensure all activities reimbursable under MAA are claimed they must be entered in InSyst. There are two types of Indirect Services Screens in InSyst, Summary screens and Detail screens. The Summary screen is used to collect hours of service performed by staff members on behalf of their programs. The recipient of the service is not a registered client. Up to 10 services can be entered at a time for a single staff member using this screen. The detail screen is **only** used to capture individual services for Alcohol/Drug programs. For detailed instruction on using the Indirect Service entry screens, please refer to the InSyst Users Manual.

Service Deletions

Seven calendar days after the entry of service data, modifications or deletions are restricted to the UBH Reimbursement Department. A *"Service Deletion Request" Form* must be submitted . Verbal requests cannot be accepted. A copy of the form is on page 47 in the Forms section of this handbook. The Service Deletion Form is kept on file to assist UBH with cost reporting requirements. Services may be deleted due to errors in data entry such as incorrect procedure codes, incorrect dates of service, and inaccurate duration of time.

Data Entry Reconciliation Process

To ensure all services have been properly entered an MHS 801, or MHS 808 Report should be generated each day for each reporting unit. The source documents for data entry should be compared against the reports to verify the data captured is accurate, and that all services have been entered. For additional information on performing the daily data entry reconciliation process, please contact the UBH Customer Service Desk.

TAKE NOTE!

MHS 801 Report can only be ordered overnight and after posting is completed for the day to be reconciled.

Determining Financial Eligibility

DETERMINING FINANCIAL ELIGIBILITY

In accordance with State Welfare and Institutions Code 5717 and 5718, all clients who are residents of the State receiving community mental health services, including involuntary admissions, are to be charged a fee according to their ability to pay, utilizing the Uniform Method to Determine Ability to Pay (UMDAP) Fee Schedule. All programs must enter the financial eligibility information into the system to ensure accurate posting of services and reporting.

Government Code Sections 240-245 and SD County Admin. Code Section 240.4: UMDAP does not require that a person have a specific period of residence in the County or State to qualify for services, therefore, intent to reside will be considered a necessary condition for the client's liability to be determined by UMDAP. Without intent to reside, the client must be billed at full cost. Any client residing out of state (including foreign national regardless of citizenship) will be billed in full. The client's verbal declaration is sufficient to decide place of residency.

In accordance with Federal, State and County policy, persons who are known to be undocumented immigrants are eligible only for emergency services, i.e, services provided by an acute hospital or Emergency Psychiatric Unit (EPU) or the Emergency Screening Unit (ESU).

Following an initial client screening process in which financial information is gathered, the three Financial Information screens in the InSyst system must be completed:

1. Special screens for California Mental Health information under Uniform Method of Determining Ability to Pay (UMDAP) (Financial, Account): Income, allowable expenses, and family size are captured in this screen. The client's fee is calculated using this information.
2. Standard Financial Liability screens for Medi-Cal information (Financial, Eligibility, Medicaid): Medi-Cal eligibility records are inserted and maintained in this screen.
3. Medicare, and private insurance coverage information (Financial, Eligibility, Policy): Private Insurance and Medicare policy information is inserted and maintained in this screen.

TAKE NOTE!

If the financial screening forms are not accurately entered in InSyst, it may affect the system's ability to accurately claim for reimbursement and affect your program's revenue.

Based on the information entered, the InSyst system will automatically calculate the client's annual UMDAP liability. For detailed instructions on completing the InSyst Financial forms, please refer to the InSyst Users Manual

Programs should routinely calculate UMDAP for *every* client prior to or during the first visit, as the annual UMDAP liability is due and payable by the client at the time of service. Program staff is responsible for verifying, communicating, and collecting, the client's financial responsibility. Once a payment is collected, contractor-operated providers are responsible to complete the "Collection of Client Account" form and forward this form to the UBH Reimbursement Unit. A copy of this form is on page 48 in the Forms section of this handbook. This is very important in ensuring the system and the client billing statements generated accurately reflect the client's financial responsibility. County operated programs should forward all client payments received on site directly to UBH for posting and deposit.

The financial screening process is required whenever there is a change in the client or families income or allowed expenses. At minimum, it must be completed annually on the anniversary of the initial mental health screening.

Client Screening

When a client visits a program for the first time, they must complete a Payor Financial Information (PFI) form, which identifies any available payor sources, and based on the sliding scale fee, is used to determine the amount the client or responsible party is obligated to pay for services. A copy of this form is located on page 42 and 43 in the Forms section of this handbook.

TAKE NOTE!

For homeless clients, please be sure to mark the "Bad Address" field with an "X".

Calculating UMDAP

UMDAP is determined by income, asset determination, allowable expenses, and family size, so it is imperative that it be as accurate as possible. Note: When calculating an UMDAP in InSyst using the payor screen, the number of dependents must include all children under 18 and parents.

Income includes gross monthly wages and/or salaries of all members of the family group. Under "other income" be sure to record total incomes from dividends, interest, rentals, support payments, and any other source of income.

TAKE NOTE!

In programs using the InSyst system, the UMDAP liability will be automatically calculated when you populate the three financial screens previously discussed in this handbook.

Asset determination includes recording all liquid assets, such as savings accounts, stocks, bonds, and mutual funds. To determine the amount of the "excess liquid assets", determine the total value of all of the liquid assets. Subtract the allowance from the "Schedule of Asset Allowances" included on the "State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule". A copy of the schedule is located on page 50 in the Forms section of this handbook. Divide the remaining total of the liquid assets by 12 and apply the result to the monthly income of the family unit.

The only deductions from gross income allowed are:

- Court ordered obligations paid monthly
- Monthly child care expenses necessary to maintain employment
- Monthly dependent support payments
- Monthly medical expense payments
- Monthly mandated deductions from gross income for retirement plans

Subtract the total of the allowable monthly deductions from the total monthly income. The result is the monthly-adjusted gross income of the family unit. Use this information, as well as the number in the family unit to determine the UMDAP liability using the "State Department of Mental Health Uniform Patient Fee and Asset Allowance Schedule" included in the forms section of this handbook.

Program staff has the authority to request verification of any financial information given by a client or responsible party. In making an inquiry to sources other than the client or responsible persons, care must be exercised to insure confidentiality requirements (Welfare and Institutions Code, Section 5328). Obtaining a signed Authorization to Release Information is recommended when verifying information with sources other than the client. The State Department of Mental Health Revenue Manual lists the following sources for verification of financial data:

- Income Tax Returns
- Drivers License or State-issued Identification
- Unemployment Documents
- Current Earnings Statements
- Employer Identification Card

The client or responsible party must be informed of the amount of the financial responsibility assessed and a payment plan established. The agreed upon payment plan is to be recorded onto the PFI. A copy of the PFI should be provided to the client and/or Responsible Party to serve as confirmation of the payment agreement. The client must also be informed of their responsibility to inform program staff or UBH of any change in financial circumstances.
Section 2.3.04 of the State Department of Mental Health Revenue Manual states that a client or responsible party has the right to refuse to give financial information; however, if such refusal is made, the client or responsible party shall be liable for the full cost of services received.

Determining Responsible Party

It is the responsibility of the person interviewing the client and completing the UMDAP to accurately determine and confirm who the responsible party is. If the client is being seen by someone other than the person performing the UMDAP, such as with case management cases, it is the staff person gathering the information from the client responsibility to **share** information regarding who the responsible party is and address to the UMDAP worker or any other staff who would be inputting account information into InSyst.

The locator screen should be reviewed when completing an UMDAP to determine if more than one person is linked to an account and the age of the client. If the client is the only person linked to the record and has turned 18 and his parent is showing as the responsible party, update the account to reflect the client as the responsible party. The only exception would be, if the client was included in the UMDAP as a minor and turned 18 during the UMDAP year and his parent has signed as the responsible party for that UMDAP period, do not change the responsible party information until the next UMDAP period. IF multiple persons are linked to the account such as siblings or parents, contact the UBH Reimbursement Department who will do the appropriate adjustment to assign the client a new account number. Remember, always check and reaffirm who should be recorded as the responsible party, if the client is divorced and the ex-spouse is showing as the responsible party, update the account to reflect the client as the responsible party. Note: All account adjustments should be completed by UBH.

Medi-Cal Referral Review

When UMDAPing clients, a review should be conducted to determine if they are potentially eligible for Medi-Cal. Any client who fit into the following categories has potential Medi-Cal eligibility and a Medi-Cal referral should be made.

1. An individual who is under the age of 21 may qualify for Medi-Cal, a referral would be appropriate if the child:
    - Do no have any other Health Insurance
    - Maybe eligible to no SOC Medi-Cal

2. A parent or caretaker relative, who have children under the age of 21 living in the home and some type of deprivation exist.
    - Absence
    - Deceased
    - A disabled parent
    - Unemployed or (underemployed – depends on hours worked and income earned)

3. Individuals between the ages of 21 and 64 who have consistently received mental health services for one year or longer and continues to be disabled and has not been denied SSI or Medi-Cal with the last Year.
    - A referral to SSI/SSP
    - A referral to Medi-Cal

4. Individuals who are disabled or blind and/or receiving Social Security Disability Benefits who do not have Medi-Cal.

5. Anyone 65 and over.

6. Anyone who is pregnant.

7. A pregnant woman and children under the age of 19 can quality for Healthy Families if their income is too high for no SOC Medi-Cal for a small monthly premium.

See attached listing on page 52 for information regarding phone numbers and locations to apply for Medi-Cal and SSI/SSP.

Screening for Other Potential Payor Sources

During the course of conducting the financial screening, program staff are responsible to review the information provided, to determine if the client may be eligible for a third party payor source such as Medi-Cal. If the client appears to be eligible, program staff is responsible for making the appropriate referrals and/or assisting clients with the application. UBH will assist programs in this function by providing a screening form and resource guide.

TAKE NOTE!

Medicare requires that the client's name appear on the claim EXACTLY as it appears on the Medicare Identification card. Please verify the spelling of the client's name in InSyst against the Medicare ID card and request any necessary corrections.

Assignment of Insurance Benefits

In accordance with California State regulations, Medicare and/or other insurance must be billed prior to billing Medi-Cal. Contracted providers are responsible for all billing to Medicare and private insurance independently. UBH is responsible for billing Medicare and private insurance for County operated programs only.

In order to bill Medicare and/or other insurance companies, a signed "Assignment of Insurance Benefits" (AOB) is required. The client or responsible party has the right to refuse to sign the assignment of benefits, however, if such a refusal is made the client or responsible party shall be liable for the full cost of services received. An AOB authorizes UBH or the contract provider to submit claims for reimbursement on behalf of the client and to receive payment directly. A "Release of Information" form should also be completed to allow UBH to provide any clinical information required for claims processing by the third party payor. A copy of the front and back of the

insurance/Medicare card should be made for both the Medical Record and for the UBH Reimbursement Department or contracted provider-billing department.

The AOB should be obtained during the first visit and updated every two years on the anniversary of the client's first visit or whenever a change in insurance has occurred. Each County and Contracted site is required to have the client fill out an AOB for their program. UBH does not collect Medicare and private insurance for contracted sites. A signed release of information form must be signed by the client and kept by each program that may be verifying insurance information. A copy of the form to be used by County and contracted staff located in the Forms section on page 44 of this handbook.

For the following payor types, please use these guidelines in completing the AOB:

Insurance

- Copy the front and back of the insurance card;
- Verify the insurance company's requirements regarding the effective period for the Assignment of Benefits/Release of Information. Some carriers require an Assignment of Benefits/Release of Information signed at each visit, while other carriers require it annually. This verification can be accomplished by calling the telephone number listed on the client's insurance identification card. Once obtained some insurance companies don't require an updated assignment of benefits or release of information, in this case a new one should be obtained every two years.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.

Medicare Beneficiaries

- Copy the front and back of the client's Medicare card;
- Verify eligibility date of Part A and B coverage. If the client has only part A or part B coverage, it must be consistent with the service being provided in order to receive reimbursement from Medicare. Part A coverage is only for inpatient treatment and Part B is for outpatient treatment;
- Obtain the client's signatures on Assignment of Benefits and Release of Information forms.
- To ensure the validity of the client's identity, obtaining a copy of the client's State issued identification is recommended.
- The client's address must be entered into InSyst accurately. If a client is homeless or an address is not available, please mark bad address.
- A current address is needed in order to bill Medicare.

TAKE NOTE!

Medi-Cal requires the entry of the Beneficiary Identification Card (BIC) issue date as a method to combat fraud. It is important the program staff obtains a copy of the client's BIC and enters the accurate issue date to assist the State in this endeavor.

Process for Determining Medi-Cal Eligibility

InSyst Registration data is compared against the State Medi-Cal Eligibility Data System (MEDS) on a monthly basis to capture Medi-Cal Eligibility information. For records with 100% matching criteria (Name, Date of Birth, and SSN), eligibility records are automatically written to InSyst. If only 2 out of the 3 data elements match, a work file called the "Partial Match Report" is created. UBH's Reimbursement Unit is responsible for correcting the Partial Match Report. Since discrepancies from MEDS require manual correction, it is imperative to ensure correct and valid information at the time of initial Registration.

Medi-Cal Eligibility records that are not captured automatically through the MEDS process must be recorded in InSyst by program staff.

To Check Medi-Cal eligibility in InSyst from the main menu:

1. Financial Maintenance Menu
2. Eligibility Maintenance Menu
3. Medicaid Eligibility Maintenance

Enter client's number – hit enter, if eligibility has already been verified for the month of service tab down to the month/year and enter "L" to look. Make sure that there is an EVC number. If no EVC number is present, there is **no** Medi-Cal eligibility for that month, enter "gold E" to exit. **Do not verify Medi-Cal eligibility for the month of service if it has already been verified.** If you are in the insert mode just read the eligibility message, do not confirm the eligibility at the bottom, enter "Gold E" to exit.

If eligibility has **not** been verified for the month of service, return to Medicaid Eligibility Maintenance, enter "Gold I" this will place you in the eligibility insert screen. Follow procedures below:

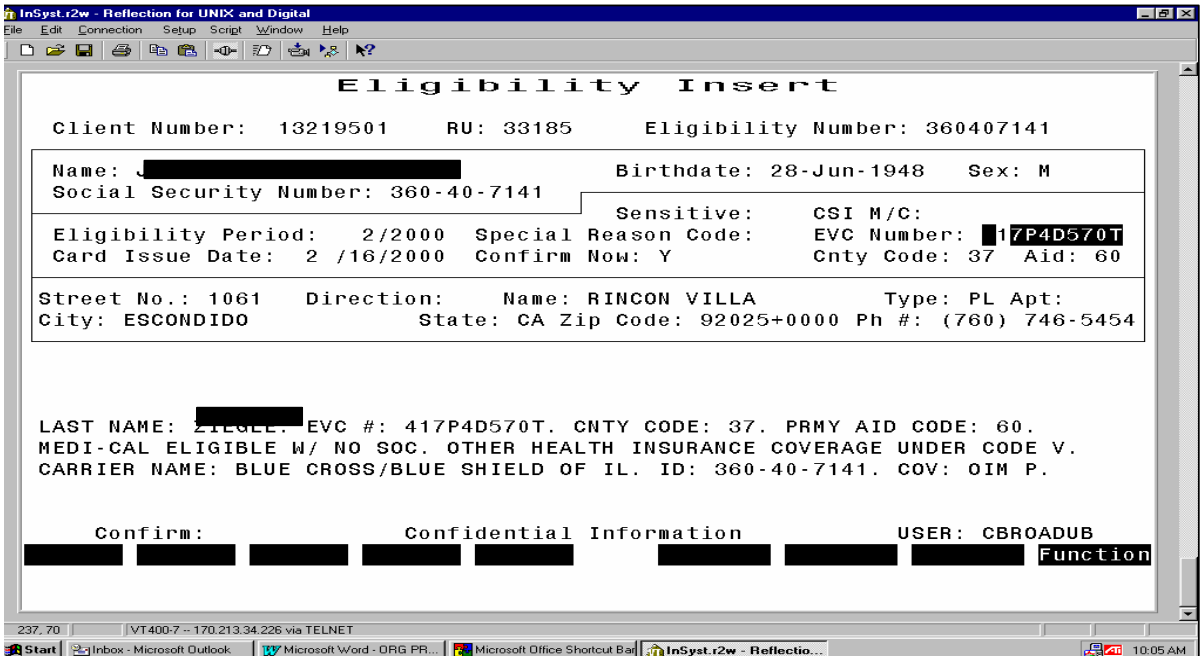
1. Enter client's number
2. Enter your reporting unit (RU) – hit enter
3. You are now at the eligibility number – if you have a copy of the card verify the eligibility number, if it is incorrect, you can type over to correct it.
4. Tab over to eligibility month enter the month & year of service you want to verify.
5. Tab over to card issue date (if you have a copy of the BIC card, use the issue date on the card) if not, enter the current date.
6. Tab over to the " Special Reason Code field", **if** the eligibility period being verified is for a **prior** month enter an "A" if not just hit enter.
7. At bottom of screen, Form OK: place a "Y" then hit the enter key. Wait a few seconds and the eligibility information will appear on screen.
8. The EVC number will be blinking (do not change any of the characters). Hit the enter key, this will take you to the bottom of the screen.
9. At the bottom of screen, it will ask to confirm: place a "Y" then hit enter key, you will then get a message successful insert (print copy of screen and attached to your data.

Note: If "**No**" recorded eligibility for the month of service shows up, it will give you a message. For example: check for possible difference in birth date or social security number. It could be a variety of reasons why there is no recorded eligibility – you may have to call the client, the client's social worker, the responsible party or if child the client's parent to verify the information.

TAKE NOTE!

Eligibility Verification Confirmation (EVC) number must be populated before confirming Medi-Cal Eligibility in InSyst.

- InSyst will compare the data against the State Medi-cal eligibility file and will populate the following fields if the client has recorded eligibility for the month of service entered.



  - Eligibility Verification Confirmation (EVC) Number
  - County Code (37 is San Diego County)
  - Aid Code
    - Determine if clients' aid code is appropriate for service. Please refer to the Department of Mental Health and Alcohol Drug Program Aid Codes Master Chart.
  - Informational message that may contain Medi-Cal share of cost data.
    - Determine when the client's share of cost has been met *(InSyst will provide the amount of the total Share of Cost and the current amount required to meet the Share of Cost).*
    - If the share of cost has been met, confirm the eligibility record.
    - If the share of cost has not been met, compare the share of cost amount to the current month total cost of service amount. Do not enter "Y" on confirm. If the current month total cost of service exceeds the share of cost, the share of cost can be cleared. For more information on Share of Cost, please refer to the next section of this handbook.
- The informational message may also contain primary insurance coverage data including the carrier name and policy identification number. Primary insurance information obtained from this process must be entered into InSyst through either the Financial Account Financial Information (FAF) screen or the Financial Eligibility Policy (FI EL POL) screen. The primary insurance information that cannot be obtained from the Medi-Cal eligibility screen such as insurance address and policy effective date, and a signed AOB, must be obtained from the client or responsible party.

Medi-Cal clients with a Share of Cost

Medi-Cal offers health care coverage to individuals and families whose income exceeds the maximum allowable. Medi-Cal requires some of these beneficiaries to contribute to their health care by paying a share of the cost for the services they received.

Share of Cost is a term that refers to the amount of health care expenses a beneficiary must accumulate each month before Medi-Cal begins to offer assistance. Once a beneficiary's health care expenses reach a predetermined amount Medi-Cal will pay for any additional covered expenses for that month. Share of Cost is an amount that is owed to the provider of health care services, not to the State.

Share of cost is different from cost sharing. "Cost-sharing" requires a beneficiary to pay a set amount or percentage of each health care service received. "Share of cost" requires beneficiaries to take full responsibility for health care expenses up to a predetermined amount. Share of cost is not a premium; it is an amount that a beneficiary is financially responsible for each month in which Medi-Cal assistance for health care expenses is needed. The amount of the Medi-Cal Share of cost is determined by the Department of Social Services.

The State Department of Mental Health policy on the certification of Medi-Cal share of cost allows the Medi-Cal Share of Cost to be certified, or cleared, by using the full cost of services received by a client during a month. The client is only held financially responsible for the amount of their UMDAP liability. If the clients' monthly share of cost is less than their UMDAP, then the monthly share of cost amount is collected until the total amount of their UMDAP has been satisfied. Each case must be reviewed to determine if the share of cost will be certified. If the client has received services in which the total cost meets or exceeds the share of cost, it should be certified. Never do partial clearing of the share of cost.

- If the client's share of cost is not certified then the client is not considered Medi-Cal eligible.
- If the client's share of cost is certified, a copy of the certification must be forwarded to the UBH Finance Department in order to account for Share of Cost certification for reporting in the State Cost Report.

Minor Consent

Clients enrolled in the Minor Consent Medi-Cal Program must meet the State Department of Mental Health's criteria for Sensitive Services. Individuals between the ages of 12 through 20 may apply for minor consent services through Medi-Cal without their parent's consent. They may also receive outpatient mental health treatment and counseling for:

- Being in danger of causing harm to self or others; or
- Being an alleged victim of incest or child abuse.

TAKE NOTE!

Minor consent Medi-Cal does not require Medi-Cal eligibility entry into InSyst effective 7/1/1998.

Mental Health services will not be billed to Medi-Cal.
Minor Consent Medi-Cal eligibility should not be entered into the InSyst system and their UMDAP liability should be set at zero. The UMDAP liability must be adjusted using "Write-Off UMDAP" adjustment discussed further in this handbook.

As of July 1, 1998 claims for specialty mental health services based on minor consent eligibility are no longer to be submitted to the Short-Doyle/Medi-Cal billing system.

However, laboratory and pharmacy services are still a benefit of the Minor Consent program and are covered through the Minor Consent client's Medi-Cal card.

Medi-Cal HMO Clients

Medi-Cal beneficiaries enrolled in a Prepaid Health Plan (PHP) are eligible to receive medical services through their HMO. These HMO policies do not cover Mental Health services. Therefore, these particular HMO's should not be entered into InSyst.

The following local Medi-Cal HMO's cover medical services only:

1. Community Health Group
2. CompCare Health Plan Inc.
3. Foundation Health, A California Health Plan
4. Great America Health Plan
5. Kaiser Permanente
6. Sharp Health Plan Advantage
7. Universal Care
8. Healthnet

Healthy Families Clients

The Healthy Families program (HFP) provides health insurance for children up to their 19th birthday whose family income is between 100 and 250 percent of the federal poverty level and therefore not eligible to Medi-Cal. Children and youth of eligible families are enrolled with a HFP health plan that provides basic health services. The mental health benefit includes twenty mental health outpatient visits and thirty days inpatient hospitalization annually to enrollees. For those HFP children and youth who meet the qualifications for being designated Seriously Emotionally Disturbed (SED), specialty mental health services are provided by the County and contracted programs. Upon determination by Children's Mental Health services that the enrollee is SED, the full range of medically necessary mental health services are available through Short Doyle/Medi-Cal Services to the extent resources are allowed.

HFP enrollees that are seeking basic mental health services at County or contracted programs shall be referred back to the HFP health plan. The only HFP enrollees that would be receiving services at County and contracted programs are those HFP enrollees who have been determined to be SED by ESU and referred to that program.

The billing for Healthy Families for Mental Health services will be conducted by UBH to the State Department of Mental Health Short/Doyle Medi-Cal system. The Human Service Specialist at ESU will confirm HFP eligibility and go into InSyst and terminate the HFP health plan policy so that billing will be allowed to Short-Doyle/Medi-Cal. ESU will provide UBH with a diskette monthly that identifies all new HFP that have been determined SED. Healthy Family clients can be identified through their aid code, which is 9H. Each County and contracted program are required to confirm eligibility monthly by verifying that the client is still an active HFP with an aid type of 9H.

TAKE NOTE!

A signed AOB is required to claim a third party payor for services rendered to any clients, however, AB2726 legislation specifically forbids claiming without appropriate authorization.

AB2726 Clients

Chapter 26.5 of the Government Code made the County Department of Mental Health responsible for providing mental health services. AB2726 stipulates that appropriate services are to be brought to the students rather than encouraging more restrictive

placement in non-public schools. The AB2726 program is a Children's mental Health program that provides mental health assessments and counseling for school-aged children and youth in order for them to benefit from their special education program. This allows students to receive highly specialized mental health services.

Because these services are a school related service, the services are provided free of charge, unless the parent consents for their private insurance to be billed .A signed AOB is required to claim a third party payor for services rendered to any clients, however, AB2726 legislation specifically forbids claiming without appropriate authorization. Emergency services and medication costs remain the responsibility of the parent, as those are not services provided through AB2726.

The local AB2726 programs refer clients to other providers if they are in need of additional mental health services. A special fund was designed by the State of California to pay for services not covered by other payor sources. For additional, information please call the AB2726 local office at (619) 221-8672.

CalWORKs Eligibility

California's public cash assistance program is called the California Work Opportunity and Responsibility to Kids (CalWORKs). CalWORKs applicants must meet state and federal regulation requirements to qualify for cash assistance. Caretaker relatives may also be eligible for benefits. Verification of the relation to the child will be required. Potential CalWORKs eligible clients should be referred to their local Family Resource Center.

Non-citizens are subject to specific regulation requirements and may wish to inquire about potential eligibility to CalWORKs. If a family provides all the necessary facts, eligibility should be determined within 45 days of the date of application. Persons with drug related felony convictions since January l, l998 are not eligible for CalWORKs.

CalWORKs mental health services are funded on a cost reimbursement basis. To ensure accurate tracking of all services and associated costs, special reporting units have been established in InSyst to track services to CalWORKs beneficiaries. Only programs authorized to render services to CalWORKs beneficiaries have been given access to those reporting units. Services provided by other programs are not eligible for CalWORKs reimbursement. If a client who is not eligible for CalWORKs mental health treatment may be in need of mental health treatment, please refer the client to the UBH Access and Crisis Line for an appropriate referral. The Access and Crisis Line, telephone number (800) 479-3339, is available 24 hours a day, seven days a week.

Private Pay (Short\Doyle) Clients

Clients who are not covered under a third party payor source should be interviewed to determine if they might be eligible for a potential funding source, such as Medi-Cal. Clients are financially responsible for the cost of service up to the amount of their UMDAP liability. If the client does not become eligible for a third party payor source, the County absorbs the cost for treatment using Realignment, Grants, and other limited funding sources.

Insurance Clients

Clients covered under a private insurance company policy are financially responsible for the cost of treatment up to the UMDAP liability. Amounts paid by private insurance companies may not be applied to UMDAP liabilities. The amount paid by the insurance will reduce the cost of treatment. Many insurance policies will pay for a portion of the cost of mental health services up to an annual maximum number of visits or an annual maximum dollar amount. To determine the amount of insurance coverage, for which a client may be eligible, you must contact the insurance company at the telephone number listed on the client's insurance identification card.

Most insurance policies require services be pre-authorized. This information can also be verified when contacting the insurance company. The pre-authorization process requires an exchange of clinical information substantiating the client's need for treatment. Under most insurance policies, treatment that has not been authorized is not reimbursable under the terms of the policy. Be sure to have a client sign an authorization of release of information form prior to contacting the insurance company.

Private Insurance Company Updates

When completing the Financial Eligibility Policy screen in InSyst, you must select the insurance company name and address that is listed on the client's insurance company identification card. If the insurance company name or correct address is not in InSyst, it must be added by UBH. County and Contracted Providers are required to complete a "Request for Insurance Addition" form, and forward it to the Reimbursement Department for processing. A copy of this form is located on page 47 in the Forms section of this handbook. UBH will notify the requestor when the insurance company has been added so the client account information can be updated.

Medicare Clients

Medicare Part B reimburses eligible outpatient services at 80% of the established Fee Schedule after an annual $110 deductible (this changes yearly). The deductible is based on the calendar year. The client is only held financially responsible up to the amount of their UMDAP liability. Medicare currently reimburses services rendered by a Physician (MD); Psychologist (PhD); Licensed Clinical Social Worker (LCSW); Physician Assistant; Nurse Practitioner and Clinical Nurse (RN). Services rendered by a Marriage Family Child Counselor (MFCC) or non-licensed staff is not reimbursable by Medicare.

Account Adjustment Requests

Account adjustments are required whenever a client account balance must be modified. The account balance is the amount for which the client is financial responsible. Authorization to enter account adjustments is limited to a number of clerical/financial staff in the programs and the UBH Reimbursement Unit. In the event an adjustment is required and program staff do not have the necessary authorization, (please contact the UBH Reimbursement Unit).

Below is a description of the various account adjustments. For detailed instructions on posting any of these adjustments in InSyst, please refer to the InSyst Users Manual.

Therapeutic Adjustment

This adjustment is utilized when a clinician determines that a client's financial obligation needs to be altered from the UMDAP fee schedule due to clinical reasons. The clinician must determine the amount of the therapeutic adjustment.

Do not enter a *"Therapeutic Adjustment"* to a full pay account. Any account in full pay status must have an UMDAP completed and a reversal of the full pay status before a Therapeutic Adjustment can be initiated. A *"Deductible Adjustment Request"* form must be completed and approved by the Program Manager/Director. This form is then submitted to the UBH Reimbursement Department for processing. A copy of this form can be found in the Forms section (page 46) of this handbook.

Bad Check Charge

Clients are charged a $25.00 fee for a returned check. Usually checks are returned due to insufficient funds. When a check is returned, the UMDAP amount that was credited will be considered not paid. For County programs, fiscal will bill the client the $25.00 returned check fee. Fiscal will notify UBH that the check has returned. UBH will add the amount of the returned check to the UMDAP balance owing. If the account is in collections UBH will notified Revenue and Recovery of the increased collection amount.

Initiate Full Pay

Often a client's financial information is not received, incorrect or incomplete and the appropriate UMDAP liability cannot be properly assessed. In these situations, the account should be set to full pay. This adjustment is used to put the account in full pay status, which makes the client responsible for the full cost of all services provided on the account. This "Full Pay" status remains in effect for the entire UMDAP period unless it is reversed using the "Reverse Full Pay" adjustment.

Reverse Full Pay

When a client's financial information is updated, and the UMDAP liability can be accurately determined, the "full pay" status must be reversed. This adjustment is used to cancel "Full Pay" status on an account and establish a new liability amount. This adjustment cancels the "Full Pay" status for the entire UMDAP period. However, any payment made on a full pay status will not be applied to the UMDAP after reversal.

Merge Account

Merge account is used when two accounts must be merged into one. For example, if a new account is created in the system for a client who already is attached to an existing account, information from the new account must be merged to the existing account. The adjustment removes the new account from the system and updates the account number in the client record for all clients attached to the account. All liabilities, services, payments, and claim records are moved to the existing account.

A system-generated account may be merged into a user-created account. However, a user-created account may not be merged into a system-generated account.

In the Adjustment Maintenance screen, the adjustment is visible through the existing or destination account number. UBH recommends this type of adjustment be referred to the UBH Reimbursement Department.

Patient Refund

Patient refunds are requested by the client or the Insurance Company, and are issued due to an overpayment on an account. Patient overpayments are included on the unapplied payment report (PSP143) which is generated monthly or as needed. UBH will review the account and determine whether the client or Insurance Company is due a refund. If it is determined that a refund is due, the back up documentation and refund request is forwarded to Health and Human Services Agency Fiscal Dept. for issuance of the refund.

Write-off UMDAP

In the event that a client's payment liability is not automatically written off due to eligibility for Medi-Cal, use the Write Off UMDAP adjustment. This will reduce the client's current account balance to zero. Enter the first day of the liability period requiring adjustment as the effective date. This adjustment requires UMDAP adjustment authorization. If program staff, do not have authorization to enter this type of adjustment, the account should be referred to the UBH Reimbursement Unit. Do not use this adjustment on a Full Pay Account.

CLAIMS, BILLING AND PAYMENT POSTING PROCEDURES

Medi-Cal Claims

When claims submitted to Medicare and private insurance carriers have been paid or denied, the residual amount is claimed to Medi-Cal. If the client does not have a primary payor source, the services are billed to Medi-Cal whenever a client has eligibility for the month of service recorded in InSyst. Eligibility data is entered by users and automatically matched against Department of Social Services and Social Security Administration eligibility data. Services to clients whose eligibility is not verified in Insyst through these processes are not claimed to Medi-Cal through the regular monthly Medi-Cal claiming process.

TAKE NOTE!

Medi-Cal will not be billed for services rendered to a client with a primary payor source until a payment or denial of the primary payor source claim line has been entered in InSyst.

There are two ways UBH claims Medi-Cal:

1. Regular Monthly Medi-Cal Claims
2. Monthly Supplemental Medi-Cal Claims

UBH is responsible for processing all data for Medi-Cal claims for all organizational providers.

1. Regular Monthly Medi-Cal Claims

UBH completes the following processes:

- Posts services daily
- Reviews all posting log files to ensure each module completed successfully
- Reviews the "SEQ_LIS" files to identify services that have not successfully completed posting
- Generate a TEST Medi-Cal Claim, and:
    - Reviews the log file to ensure successful completion.
    - Reviews and compares the current Medi-Cal claim totals with previous months.
    - Analyzes Report MHS 150 to determine if the totals are within normal range.
    - If the claim total is below normal range researches to determine problem.
    - Runs the various Medi-Cal eligibility processes.
    - Contacts individual program sites that are claiming below normal range.
- Submits Medi-Cal eligibility (POE) and service posting modules.

- Submits final Medi-Cal claim
    - Reviews log file to ensure successful completion.
    - Prints Report MHS 150, Medi-Cal Claim Analysis, and Medi-Cal Claim form MH 1980

2. Monthly Supplemental Medi-Cal Claims

All Medi-Cal services that were not paid through the Regular monthly or Social Security Number claiming process will be submitted through the supplemental Medi-Cal process, which generates a monthly claim for prior fiscal year services.

Medi-Cal Error Correction Reports

The State of California distributes Medi-Cal Error Correction Reports (ECRs) to UBH for services that do not clear the billing edits. UBH manages all ECRs. When ECRs are received, they are logged into a tracking system and disbursed to programs for correction the day after it is received by UBH.

TAKE NOTE!

All corrections to the ECR must be completed in GREEN INK as required by the State. The ORIGINAL must be returned to UBH within 10 business days.

As required by the State, all corrections to the ECR must be completed in *"GREEN INK."* The *original document* must be returned to UBH within 10 business days. In the event ECRs are not resubmitted to UBH by their due date, a call is placed to the agency contact person to determine the status of the ECR. If the ECR is not completed in a timely manner, UBH will notify the Program Manager. If necessary, UBH will also notify the Contractor's Chief Financial Officer (CFO). Medi-Cal will deny payment for services on the ECR that are not corrected and resubmitted to the State within the designated time frames. Failure to complete the ECR will result in UBH sending a letter to the provider stating the program is in non-compliance with the terms of the contract.

Steps to Editing ECRs

Use the following list of "Error Messages" as a guide when completing ECR edits.

1. *XOVER INDICATOR (FIELD 22)*
   Error Message: M/CARE COV. AB

This indicates that the client is a Medicare beneficiary. Claims to Short-Doyle/Medi-Cal for services provided to Medicare beneficiary should be claimed only after Medicare reimbursement/denial documentation has been received. There are two kinds of corrections that could be made depending on whether the service provider is a certified Medicare provider or not:

Corrections (Provider is a certified Medicare provider):
If the service has not been billed yet to Medicare, or if it has been billed but a response (i.e.: remittance advice) is not received prior to the deadline for submission of ECR, place an "X" in the override code to cancel the claim.

/X/ / / / / / / / / / / / / / /

A. If the service has already been billed to Medicare and was denied, enter an "X" in field 22 correction box.

B. If paid, enter an "X" in the correction box for field 22 and enter the new Medi-Cal amount in field 21 (total billed amount minus payment).

/ / / X/
/ 0/0 /0 /3 /7. /0 /0 /

C. If the client was Medicare eligible but the service was not enter an "N" in the correction for field 22

/ / / N/
/ 0/0 /0 /8 /7. /0 /0 /

2. Corrections (Provider is not a certified Medicare provider):

Place an "H" in the correction box for field 22 and post the same Medi-Cal billed amount on the ECR.

/ / / H /

* Do not recopy data that is correct. It is not necessary to recopy the dollar amount if it is correct.

3. *Error Message: OTHER HEALTH COVERAGE CODE*

Corrections:

If the service has not yet been billed to private insurance, or if it has been billed but a response is not yet received (Payment or Denial Letter) prior to the deadline for submission of the ECR

Place an "X" in the Override Code, this will cancel the Medi-Cal claim
/X/ / / / / / / / / / / / / / /

If the service has already been billed to private insurance but payment was denied, enter "P" in the correction box for field 22.

If provate insurance has been billed and made payment, enter "P" in correction box for field 2 and enter the net amount (total billed less payment in field 21 boxes.

/ / / P

/ 0/0 /0 /8 /7. /0 /0 /

Note: An "X" in the override bracket next to any line will immediately remove that claim from the MSD/EDIT System.

4. Ineligible in MO/YR (Field 10)

Error Message indicates that there was no match found in the MEDS system. Verify the client's eligibility in InSyst:

- Go to the Financial Eligibility Medicaid screen in Insyst and use the GOLD I function to verify the month of service eligibility. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT CONFIRM with "YES". You must confirm with "NO" or Gold-E to exit screen.

- If the client is eligible, enter a "W" in the override code on the ECR.
- Verify the Social Security Number on the ECR matches the number in InSyst. If there is a discrepancy, note the correct number on the ECR.
- Write in the County and Aid code in the first four spaces provided in the correction field.
- If the Social Security Number (SSN) is correct but the client does not have eligibility put an "X" in the override code.

At times the error message "INELIGIBLE IN MO/YR" may appear due to the client having an unmet Share of Cost (SOC). To determine the client's SOC amount:

- Verify the month of service eligibility in InSyst. If the client does not have recorded eligibility, DO NOT CONFIRM!
- Go to the Service Maintenance screen to determine if client has sufficient services for the month to certify the SOC.
- If the cost of services total less than SOC, enter an "X" in the override code to cancel the claim from Medi-Cal.
- If services total more than SOC, clear client's SOC. (For more information on Share of Cost Certification, please refer to the Medi-Cal Share of Cost section of this handbook). To correct ECR write the SSN on field 10 and write "SOC" to the right of the error message.

5. Invalid Code (Field 10)

The Medi-Cal BIC (Benefit Identification Card) changed as of 01/01/05 to a 14 character Alphanumeric ID. By 7/01/05, the Social Security Number will be removed from all BICs.

- Determine if there is a discrepancy in the SSN.
- Leave the override code blank.
- Correct SSN in the correction field 10.

6. Not on Eligibility File (Field 10)

This error message indicates that client's SSN is incorrect.

- Verify the client's correct SSN and check eligibility for the month of service.
- Leave the override code blank and use the correction field to enter correct SSN.
- Verify the month of service eligibility in InSyst Eligibility Insert screen. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT CONFIRM with "YES". You must confirm with "NO" or Gold-E to exit screen.

7. No Secondary Match

This error message coincides with "NOT ON ELIGIBILITY FILE." If the SSN is incorrect, all other related information will be incorrect as well. Use the correction field to enter all the correct information (i.e. Last name, sex or year of birth).

- Submit a "Change of Information" (see the Forms section of this handbook) to County Medical Records Staff, specifying the Name, Date of Birth and SSN from MEDS.

8. Provider Not on File (Field 3)

- Correct the provider number.
- There is no override for this error.

9. Patient Name (Field 8)

This error message indicates that there is "NO MATCH FOUND" in the MEDS file.

- Verify the month of service eligibility in InSyst Eligibility Insert screen. If the client does not have an Eligibility Verification Code (EVC) number, DO NOT

CONFIRM with "YES". You must confirm with "NO" or Gold-E to exit screen.

- Verify the client's name and check for spelling errors.
- If the name is incorrect, make the corrections in the correction field of the ECR.
- If the last name is different use the name provided in the MEDS file.
- Submit a "Change of Information" (see the Forms section of this handbook) to County Medical Records Staff, specifying the Name, Date of Birth and SSN from MEDS.

Insurance Billing

UBH is responsible for billing private insurance carriers for all County operated program. Contract providers are responsible for retaining adequately trained billing staff and producing claims to insurance carriers. Claims should be generated, at minimum, on a monthly basis. The HCFA 1500 form must be completed in its entirety. If authorization for treatment was obtained from the insurance company, the authorization number should be referenced on the HCFA 1500 form. The business standard for resolving outstanding account receivables is 120 days from the date of service.

Below are general guidelines, which apply to most third party payor billing:

- Ensure the subscriber identification number on the claim matches the number of the member's insurance identification card. Although the identification number is usually the subscriber's social security number, this is not always the case.
- The claim must clearly indicate that the Assignment of Benefits form is completed. This is accomplished by entering "Signature on File" in the Assignment area of the HCFA 1500.
- If the provider of service is enrolled as a provider in an HMO or PPO and has been assigned an identification number, that number should be referenced on the claim.

Medicare Billing

To be updated at a later date.

Account Collections

The most effective way to resolve outstanding accounts receivable balances is to follow up billings with a telephone call to the insurance carrier. At minimum, follow up should occur for all outstanding claims every 30 days.

Below are some general guidelines that may assist in this process:

- If the insurance carrier indicates they did not receive the claim, ask if the claim can be faxed. This will alleviate unnecessary delay of re-submitting the claim by mail.
- If the insurance carrier states they could not identify the client, provide them with the information from the client's identification card. If necessary, fax a copy of the insurance card.
- If the insurance carrier indicates the client was not eligible for benefits, provide them with the name of the individual in their organization that verified benefits and eligibility (if applicable).
- If the insurance carrier indicates the services were not authorized, determine if program staff obtained authorization. If so, provide the carrier with the authorization information.

- If the insurance carrier indicates there is a primary payor, obtain that information. Contact the carrier they indicated was primary to determine if the client is eligible for coverage.
- The business standard for resolving outstanding claims is 120 from the date of service.
- When utilizing the InSyst MHS115 and MHS116 reports as a follow up tool, note an asterisk (*) indicates the client has Medi-Cal as a secondary payor. Medi-Cal will not be claimed until the primary claim line has been closed through entry of a payment or a denial.

Client fee collection for contracted providers should be conducted, at minimum, once every 30 days. The most effective collection method for patient fees is to discuss their financial obligation with them when they are present for treatment. In no case should the client be denied treatment based on financial issues.

For County programs only, client billing statements are generated quarterly. UBH will collect quarterly on all outstanding accounts until they become delinquent. All delinquent accounts will be referred to the Office of Revenue & Recovery (ORR). A delinquent account is one in which payment is not received by Mental Health Services(MHS) within 45 days from the date the client statement for the final account balance (UMDAP amount or final UMDAP liability period balance) was generated by UBH on expired UMDAPs.

Insurance/Medicare Payment Posting

This process is utilized to capture payments in InSyst for all payor sources except client payments. After a series of processing steps, payments are applied to the corresponding claim lines. Through the "Payment Entry" screen, payments can be targeted to specific claim lines or divided and applied to

several claim lines. Payment entry, through the payment entry screen, is the first stage of payment processing, whereby a payment or portion of is linked to a claim line. If no services are located, the payment will be held in a "Unapplied Status." Payments should be entered into InSyst daily.

1. **The steps in posting insurance or Medicare payments are as follows:**
   - Go to the Financial Revenue Enter screen.
   - Key an "X" next to the appropriate payor type (Medi-Cal, Medicare, and Insurance).
   - Key a "Y" on "FORM Y/N", and press the enter key.
   - If the payment is from Medicare:
     - Type the Eligibility Number (which is the Medicare Number showing on the EOB).
     - If the record cannot be found, type the Client name *(Last name first, then the First Name)*.
     - A list of client's names will be displayed. Key an "X" on the appropriate name.
     - Key in the Service dates from the Remittance Advice.
     - If a claim was generated, enter the EOB date, and receipt Number. Press the Tab key.
     - If the claim line was denied prior to an appeal payment, the claim line must be re-opened through the Financial Claim Claim (FI CL CL) screen.

- Key in the Total Approved Amount and Total Payment Amount (*if there is only 1 claim line, press the enter key, then enter "Y" on FORM Y/N).*
- If the payment is for more than one claim line, enter the appropriate amount of the payment on each claim line.
- Key a "Y" when complete to enter a payment for another client. If there are no additional payments, exit the payment entry screen.

If the payment is from Private Insurance:

- Key an "X" on Insurance, and then key a "Y" on FORM Y/N.
- Type the Eligibility Number, the client number, or the client's name.
- Type the service date from the Explanation of Benefits (EOB).
- Select the claim or claim lines and enter the EOB date and the receipt number.
    - Press the Tab key to the Total Payment Amount field and enter the amount of the payment. *(If there is only one claim line, press the enter key to move the cursor to the FORM Y/N, and enter "Y". Otherwise, key in the payment for each claim line).*
- Press the enter key. The cursor will go to FORM Y/N prompt. Key a "Y" to confirm, and press the enter key.

Client Payment Posting

All client payments must be captured in InSyst to ensure clients are held financially responsible only up to their UMDAP liability and to ensure accurate revenue reporting. UBH is responsible for posting client payments for all programs. Contract operated programs must report client payments received to UBH via the "Collection of Client Account" form for posting to the InSyst system. A copy of this form is on page 49 in the Forms section of this handbook.

County operated programs should process client payments in accordance with San Diego County Policies and Procedures.

Insurance and Medicare Denials

In the event that an insurance company denies a payment, consider the reason. If the company does not provide a satisfactory explanation or the denial appears questionable, request clarification by calling the insurance company.

A request for reconsideration of payment is referred to as an appeal. An appeal is usually a letter, submitted with a claim and clinical documentation supporting the medical necessity for the services rendered that have been denied.

The following list of denial reason codes for entry into InSyst are recommended for appeal:

1. **E:** No pre-authorization for emergency visits. Need to request additional information from Medical records.
2. **C:** Policy does not cover services. Provide documentation of the Medical necessity and send it to the insurance company, if available.

These denial reason codes are recommended for rebilling or submission to the appropriate insurance carrier:

1. **F:** Coverage canceled. Determine if there is a new active insurance policy.
2. **A:** Maximum insurance benefits paid. Determine if there is a secondary payor.

3. **B:** Applied to deductible. If applicable, the secondary payor is responsible for the billed amount.
4. **I:** Patient not enrolled; and **D:** primary carrier covers services. Usually, the denial letter will state the name of the insurance company who will handle the claim and an address where to send it.
5. **G:** No record of concurrent physician. Provide physician information.

For detailed instructions on entering denials into the InSyst system, please refer to the InSyst Users Manual.

Payment Audit Procedures

Contracted providers are responsible for posting payments and denials in InSyst to ensure that accounts receivables are tracked and available for reporting. In addition, as all Medi-Cal claiming is conducted through InSyst, primary payor source payment and denial information must be entered in InSyst to ensure appropriate claiming to Medi-Cal. Once payment posting has been completed, the MHS 172 report is printed automatically at the provider's printer queue. All payments must be reviewed for accuracy and verified on this report. If all payments posted are correct, the report is signed and forwarded to the UBH Reimbursement Unit. The UBH Reimbursement Unit will move the payments from a "To Audit" status to a posted status upon receipt of the MHS 172.

The MHS 171 is a report that shows UBH all aged payments that have not moved to the final posting process. This report is also necessary to make sure that all payments are posted, ensuring that all Medi-Cal claims (secondary claims) are billed. This report serves as a tracking report to ensure all MHS 172 reports are confirmed and received by UBH.

Provider Tracking Report

UBH is responsible for tracking the contracted providers' billing functions and providing summary information to the County of San Diego of their status and provide detail information to the Contractor via the Provider Tracking Report. This report is reviewed by County Program Monitors to ensure that programs keep the numbers to a minimum. The monthly tracking report includes information pertaining to the following:

- Identify outstanding amounts Medicare/Insurance claim lines that need to be satisfied via a payment or denial entry to ensure billing of secondary payor.
- Ensure that all potentially billable services have an active account/UMDAP
- Ensure that service posting is timely and accurate
- The number of deletions requested by the Provider.
- The number of incomplete Insurance Policies.

The following InSyst reports are utilized by UBH staff to evaluate each contracted provider's financial activity:

- *MHS 115* – is a summary report used to determine the focus and level of collection efforts. This report also allows users to focus on the crossover claims so they can bill the residual amount to Medi-Cal within the designated time frames of one year from the date of service.
- *MHS 116* – is a detailed report used to determine the focus and level of collection efforts. This report also allows users to focus on the crossover claims so they can bill the residual amount to Medi-Cal within the designated time frames of one year from the date of service.

- *PSP 131* - used to audit service entry and program productivity.
- *PSP 138* - used to monitor the timeliness of data entry into the system.
- *MHS 173* - used to monitor monthly Medicare and Insurance payments entered.
- *PSP 577* – used to monitor missing or incomplete AOBs.
- *MHS 164* – used to identify which UMDAPs are due to be renewed in the next calendar month.
- *MHS 158* – used to monitor missing UMDAPs.

TRAINING & TECHNICAL ASSISTANCE

It is very important for any program staff that will use InSyst to attend UBH's comprehensive training course to learn how to use the system correctly. The training is free of charge, and is necessary in order to receive data entry authorization.

InSyst Basic Screens training is offered every month. Reports training or special module training is also available. To register for classes, or to obtain a copy of the training schedule, please call the UBH help desk Financial Training at (619) 641-6928.

The UBH MIS Customer Service Desk is also available to assist program staff with technical support or special requests.

Telephone: (619) 641-6928
Facsimile: (619) 641-6975
E-mails from within the InSyst network: *UHELPDUB*
E-mails from the Internet: helpdesk@sdubh.com

All requests for the UBH MIS Customer Service Desk will be logged into a tracking system, and a Technical Support Specialist will be assigned to assist with the request.

The UBH Training Department provides a full range of provider training on topics related to the provision of services in the San Diego County Mental Health System.

User Manual and Reports Manual

Every County operated and contractor operated program using InSyst should maintain an updated copy of the InSyst Users Manual and the InSyst Reports Manual that were sent to all programs during system implementation. New programs or existing programs with a need for new manuals may request them from UBH by calling (619) 641-6928.

The appendices to the User Manual contain important information related to data codes allowed in the system. These appendices are updated from time to time and mailed to providers. Managers should ensure that the appendices are updated in the Manual and that personnel are aware of the changes.

QUICK REFERENCE LIST

ACCESS AND CRISIS LINE	(800) 479-3339
PROVIDER LINE (800) 798-2254	
MIS CUSTOMER SERVICE DESK E-mails from within the InSyst network: UHELPDUB E-mails from the Internet: helpdesk@sdubh.com	(619) 641-6928
FAX	(619) 641-6802
Clinical	(619) 641-6729
Provider Services and Quality Improvement	(619) 641-6979
Finance	(619) 641-6975
UNITED BEHAVIORAL HEALTH, SAN DIEGO	(619) 641-6800
Reimbursement Department Main Line	(619) 641-6866
Reimbursement Supervisor	(619) 641-6822
Finance Trainer	(619) 641-6849
Finance Technician	(619) 641-6855
Billing Coordinator	(619) 641-6996
Collections Specialist	(619) 641-6823
SAN DIEGO MHP MENTAL HEALTH ADMIN.	(619) 563-2745
PATIENT ADVOCACY PROGRAM	(619) 260-7660
COUNTY CONTACT	(619) 584-5028

FORMS

- New Staff Provider Assignment Form
- InSyst Client Registration Form
- Episode Opening/Closing Form
- Payor Financial Information Form
- Assignment of Insurance Benefits Form
- Change of Information Form
- Deductible Adjustment Request Form
- Service Deletion Request Form
- Request for Insurance Company Addition
- Collection of Client Accounts
- UMDAP Fee Schedule

NEW STAFF/PROVIDER ASSIGNMENT FORM

TO BE COMPLETED BY APPLICANT			
Please check one: ☐ New ☐Modify ☐Terminate		Date:	
Staff No. (for change or termination only):		First Name Middle Initial Last Name	
Sex:	SSN:	Phone#:	Start Date: (MM/DD/YY)
Ethnicity: (Please refer to list attached)		Birthdate: (MM/DD/YY)	End Date: (MM/DD/YY)
UPIN (For physicians only):		Number (Professional License):	
Medicare PIN (For physicians only):		Renewal: (MM/DD/YY)	
DEA Number:		State:	
Language Spoken: (Please refer to attached list of valid Language codes. List all languages that apply)			
Staff Mask (Please check **ONE** only):			
☐ Educator ☐ MFC Counselor ☐ Intern ☐ Nurse ☐ Medical Records	☐ Occ Therapist ☐ Pharmacist ☐ Physician ☐ Physician Assistant ☐ Psych Tech	☐ Psychiatrist ☐ Psychologist ☐ Rehab Counselor ☐ Social Worker ☐ Unlicensed Worker	
Applicant's Signature			Date
Immediate Supervisors Signature			Date
FOR UBH USE ONLY			
_____ Director of MIS, UBH		_____ Date	
Staff No.	Date Activated/ Changed/ Terminated:	By:	

INSTRUCTIONS FOR COMPLETING NEW STAFF/PROVIDER ASSIGNMENT FORM

1. **DATE**: The date form was completed.
2. **FIRST NAME/MI/LAST NAME**: The full name (e.g. John L. Doe) of the person who needs a staff number.
3. **SEX**: Enter **F** for Female; **M** for Male; **O** for Other and **U** for Unknown.
4. **SSN**: Enter staff's 9-digit Social Security Number.
5. **START DATE**: Enter staff's effective date in MM/DD/YY format.
6. **ETHNICITY**: Refer to Valid Ethnicity Codes listed on the form. **You can enter up to two ethnicity codes**.
7. **BIRTHDATE**: Enter date of birth in MM/DD/YY format.
8. **END DATE**: Enter staff's termination date in MM/DD/YY format.
9. **UPIN**: (For physicians only). Enter UPIN number.
10. **MEDICARE PIN**: (For physicians only). Enter Medicare PIN, if available.
11. **DEA NUMBER**: Enter DEA number (for drug prescriptions).
12. **NUMBER**: Enter professional license number.
13. **RENEWAL**: Enter renewal date of professional license.
14. **STATE**: Enter state where professional license was issued.
15. **LANGUAGE SPOKEN**: Please list all the language(s) that the staff can speak. This is crucial in servicing clients/patients.
16. **STAFF MASK**: Please check appropriate box or check all that apply.
17. **APPLICANT'S SIGNATURE/DATE**: The signature of the applicant requesting a staff number (required field), and the date the application is submitted.
18. **IMMEDIATE SUPERVISOR'S SIGNATURE/DATE**: The applicant's immediate supervisor's signature is required to acknowledge and approve the request for a staff number.
19. **DIRECTOR OF MIS UBH**: MIS Director's signature is required for all user authorization forms.

Valid Ethnicity Codes

A = White	**L** = Filipino	**W** = Ethiopian
B = African American	**M** = Other Asian	**X** = Somali
C = Native American	**N** = Other	**Y** = Iranian
D = Mexican American/Chicano	**O** = Korean	**Z** = Iraqi
E = Other Latin American	**P** = Pacific Islander	**1** = Amerasian
F = Puerto Rican	**Q** = Korean	**2** = Samoan
G = Chinese	**R** = Hmong	**3** = Asian Indian
H = Vietnamese	**S** = Cuban	**4** = Hawaiian Native
I = Laotian	**T** = Dominican	**5** = Guamanian
J = Cambodian	**U** = Salvadoran	**6** = Multiple (only valid in subfield B)
K = Japanese	**V** = Sudanese	

Valid Language Codes

☐ English	☐ Mandarin Chinese	☐ Hebrew
☐ Spanish	☐ Cantonese Chinese	☐ French
☐ Tagalog	☐ Other Chinese	☐ Polish
☐ Japanese	☐ Hmong	☐ Russian
☐ Filipino Dialect	☐ Farsi	☐ Portuguese
☐ Vietnamese	☐ Arabic	☐ Italian
☐ Laotian	☐ Other Sign Language	☐ Samoan
☐ Cambodian	☐ Armenian	☐ Thai
☐ Sign Language	☐ Ilacano	☐ Unknown/ Not Reported
☐ Other	☐ Mien	
☐ Korean	☐ Turkish	

INSYST CLIENT REGISTRATION FORM (Revised: 02/03/05)
☐ **Registration** ☐ **Update**

***** PLEASE NOTE THAT BOLDED FIELDS ARE REQUIRED!!! *****

+REGISTRATION SCREEN

INSYST CLIENT NUMBER:	**REPORTING UNIT**:	
LAST: **FIRST:** MIDDLE: GENERATION:		
BIRTHDATE:	**SEX:**	**SSN:**
EDUCATION:	**OTHER FACTORS:**	OTHER ID:
DISABILITY:	SERVICE GROUP:	LOCAL CODE:
LANGUAGE:	PRIMARY RU:	PROGRAM CODE:
ETHNICITY:	CHART LOCATION:	RESEARCH ITEM:
HISPANIC ORIGIN:	REF. STAFF ID:	
MARITAL STATUS:	FAMILY SIZE:	ANNUAL INCOME:
ALIASES: LAST FIRST MIDDLE		
CLIENT BIRTH NAME:LAST **FIRST** MIDDLE GENERATION		
BIRTH PLACE:	**MOTHER FIRST NAME**:	

ADDRESS SCREEN

STREET NUMBER:	CITY:
DIRECTION:	STATE: ZIP CODE:
NAME:	
TYPE:	PHONE NUMBER:
APARTMENT:	CENSUS TRACT:
BAD ADDRESS:	COUNTY OF RESPONSIBILITY:

Confidential Information

Significant t Other Screen

NAME **LAST**:	**FIRST:**	**EFFECTIVE DATE:**
RELATIONSHIP TO CLIENT:		EXPIRATION DATE:
STREET NUMBER:	CITY:	
DIRECTION:	STATE:	ZIP CODE:
NAME:	COUNTRY:	
TYPE:	HOME PHONE:	
APARTMENT:	WORK PHONE:	
COMMENT:		

☐EMERGENCY CONTACT ☐CLIENT'S GUARDIAN ☐FAMILY MEMBER ☐DON'T DISPLAY ON REPORTS

☐PRIMARY CAREGIVER

San Diego County Organizational Providers

EPISODE OPENING/CLOSING FORM **Date:** _____

☐ **Update**

EPISODE OPENING

CLIENT NAME:				**CLIENT NUMBER:**	**RU:**
STREET NO.:		DIRECTION:		STREET NAME:	
TYPE:		APT:		CITY:	
STATE:	ZIP CODE:			PH#: ( ) x	
Initial Diagnostic Impression					
OPENING DATE:		**REFERRAL FROM:**		**LEGAL:**	
AXIS 1: P/S	AXIS 2: P/S	AXIS 3:	**AXIS 4:**	**AXIS 5:**	**PAST:**
AXIS 1:	AXIS 2:	AXIS 3:			
CLINICIAN ID:		**LIVING SITUATION:**	ADMISSION HOUR:		SCHEDULED (FOR IP ONLY):
PHYSICIAN ID:		**EMPLOYMENT STATUS:**	LEGAL CONSENT:		
SOURCE OF INCOME:		TYPE OF EMPLOYMENT:	RESEARCH ITEM:		
PATIENT LOCATION:			EFFECTIVE:		

EPISODE CLOSING

Final DSM-4 Diagnostic Impression					
CLOSING DATE:			DISCHARGE HOUR:	**LEGAL:**	
AXIS1: P/S	AXIS 2: P/S	AXIS 3:	**AXIS 4:**	**AXIS 5:**	PAST:
AXIS 1:	AXIS 2:	AXIS 3:			
CLINICIAN ID:		**LIVING SITUATION:**		**REFERRALS:**	
PHYSICIAN ID:		**EMPLOYMENT STATUS:**		**REASON FOR DISCHARGE**:	
				RESEARCH ITEM:	

ESU, EPU & IP PROGRAMS ONLY

RELIGION:	BROUGHT FROM:
	BROUGHT BY:

CHILDREN PROGRAM'S ONLY

NAME OF SCHOOL:	
CLIENT'S SCHOOL DISTRICT:	CLASS PLACEMENT:

InSyst Payor Financial Information

New Account ☐
Annual Re-determination ☐
Revision to Existing UMDAP ☐

Client Name _____ Client No. / Account No. _____ / _____

UMDAP Liability Period From: _____ / _____ / _____ To: _____ / _____ / _____

Number of Dependents: _____ Undetermined Liability: _____

A. Monthly Income		B. Total Assets		C. Monthly Expenses	
1. Self	$	1. Checking	$	1. Court Ordered	$
2. Parent/Spouse	$	2. Savings	$	2. Child Care	$
3. Other	$	3. Other	$	3. Dependant Support	$
4. Total Income	$	4. Total Assets	$	4. Retirement	$
5. Adjusted Income	$	5. Asset Allowance	$	5. Total Medical	$
6. Annual Liability	$	6. Met Assets	$	6. Excess Medical	$
7. Quarterly Payment (County)	$	7. Monthly Assets	$	7. Total Expenses	$
Monthly Payment (Contractor)	$				

Employment Information

Responsible Party (RP) Employer	Spouse's Employer
Name _____	Name _____
Address _____	Address _____
City, State, Zip Code _____	City, State, Zip Code _____
Phone	Phone

Insurance Information

1. Medi-Cal Number _____ Eligibility Period _____
2. Medicare Number _____ Part A Effective Date _____ Part B Effective Date _____
3. Name of Insurance _____ ID Number _____

Billing Address _____

Group Number _____ Effective Date _____

Policy Number _____ Expiration Date _____

Insured Person's Name _____ Insured Person's Gender: ☐Male or ☐Female

Insured Person's Social Security Number ___ / ___ / ___ Relationship to Insured _____

☐Employment Related ☐Assignment of Benefits ☐Release of Information ☐Information Complete

Signatures

I understand that I am obligated to pay the established UMDAP deductible or the actual cost of services received during the UMDAP contract year, whichever is less. I understand that I am obligated to pay for the cost of care up to the UMDAP deductible regardless of when treatment is terminated.

Responsible Party Name (Print) _____ Interviewer's Signature _____

Signature of Responsible Party _____ Date _____

San Diego County Organizational Providers
Información Financiera de Pagador de INSYST

Cuenta nueva ☐
Predeterminación anual ☐
Revisión de UMDAP existente ☐

Nombre de cliente: _____ Número de cliente/Número de cuenta: _____/_____

Período de responsabilidad de UMDAP Desde: ____/____/____ Hasta: ____/____/____

Número de cargas: _____ Responsabilidad no determinada: _____

A. Ingreso mensual		B. Activos Totales		C. Gastos Mensuales	
8. Propios	$	1. Cuenta corriente	$	1. Por orden judicial	$
9. Padres/cónyuge	$	2. Ahorros	$	2. Cuidado de hijos	$
10. Otros	$	3. Otros	$	3. Apoyo de cargas	$
11. Ingreso total	$	4. Activos totales	$	4. Jubilación	$
12. Ingreso ajustado	$	5. Asignación de activos	$	5. Total gastos médicos	$
13. Responsabilidad anual	$	6. Activos netos	$	6. Exceso de gastos médicos	$
14. Trimestralmente (Condado)	$	7. Activos mensuales	$	7. Total gastos	$
Mensualmente (Contratista)	$				

Información del Trabajo

Empleador de la parte responsable (RP)	Empleador del cónyuge
Nombre: _____	Nombre: _____
Dirección _____	Dirección _____
Ciudad, Estado, Código Postal _____	Ciudad, Estado, Código Postal _____
Teléfono: _____	Teléfono: _____

Información del seguro

4. Número de Medi-Cal _____ Período de elegibilidad _____
5. Número de Medicare _____ Fecha efectiva Parte A_____ Fecha efectiva Parte B _____
6. Nombre del seguro _____ Número de identificación _____

Dirección de facturación _____

Número de grupo _____ Fecha efectiva _____/____/_____

Número de póliza _____ Fecha de vencimiento _____/____/_____

Nombre de la persona asegurada Sexo del asegurado: ☐M or ☐F

SSN del asegurado _____ ____ _____ Relación con el asegurado _____

☐ Relación con el trabajo ☐ Asignación de beneficios ☐ Entrega de información ☐ Información completa

Firmas

Entiendo que estoy obligado a pagar el deducible o los costos reales de los servicios de UMDAP establecidos y recibidos durante el año de contrato de UMDAP, aun cuando sea una cantidad menor. Entiendo que estoy obligado a pagar el costo de la atención hasta el deducible de UMDAP, sin considerar la fecha de término del tratamiento.

Nombre de la parte responsable (letra imprenta) _____ Firma del entrevistador _____

Firma de la parte responsable _____ Firmado con fecha _____

County of San Diego Health and Human Services Agency Mental Health Services Información Financiera de Pagador de INSYST HHSA-MHS 933 005)	Client _____ MR/Client ID#: _____ Program: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I/We _____ Patient M.R. _____ F/P# _____

Policyholder _____ Relationship to Patient _____

do hereby assign to the County of San Diego, or agencies contracted by the County of San Diego, any covered Insurance Benefits payable. (Please refer to your insurance policy or contact your insurance agent for assistance in completing the following.)

INSURANCE COMPANY _____
COMPANY ADDRESS _____
POLICY NUMBER _____ CERTIFICATE/MEMBERSHIP NUMBER _____

EFFECTIVE DATE _____ ENROLLMENT CODE _____ PATIENT'S BIRTHDATE _____
PATIENT'S SOCIAL SECURITY NUMBER _____
POLICYHOLDER'S SOCIAL SECURITY NUMBER _____
UNION LOCAL NUMBER _____

PLEASE SIGN IN BOTH PLACES BELOW

FOR GROUP INSURANCE

Insurance companies must have the following information, in addition to any of the above that may apply, before payment on insurance claim can be made.

Name of Employer _____

Address of Employer _____

Group Policy Number _____ Certification/Membership Number _____

I understand and agree that I/We are responsible to the County of San Diego or Contracted Agency for all charges not paid by this agreement or as determined by Uniform Method of Determining Ability to Pay (UMDAP).

I/We authorize the release of information regarding care received at the County of San Diego Mental Health Services or a Contracted Agency in San Diego County, as requested by the Insuring Agency.

Date _____ Patient's Signature _____
Date _____ Policyholder's Signature _____

County of San Diego
Health and Human Services Agency
Mental Health Services

ASSIGNMENT OF BENEFITS

HHSA: MHS-071 (09/2004)

Client: _____

MR/Client ID#: _____

Program: _____

County of San Diego
Health and Human Services Agency
Mental Health Services

CHANGE/ADDITION OF INFORMATION

	Change From	**Change To**
Patient's Name	_____	_____
Birthdate	_____	_____
Medical Record #	_____	_____
Client Number (S#)	_____	_____
Social Security #	_____	_____
Race	_____	_____
Sex	_____	_____
Telephone #	_____	_____
Address	_____	_____

Justification for Making Change:

_____ Medi-Cal Verified/Sticker Received (Date) _____

_____ Other Verification Documents Received/Verified (Date) _____

List Documents _____

_____

_____ Personal Identification (Date) _____

By Whom _____

Remarks _____

_____

Originator (Name/Location) _____

Date _____

Phone # _____

Distribution:

Original – Mental Health Medical Records Services (P-531)

1st Copy – MIS (P-531E)

2nd Copy – File Copy for Originator

3rd Copy – Service Program (Therapist)

HHSA:MHS(02/2005)

County of San Diego – Health and Human Services Agency
Mental Health Services

Route via (#) below
as necessary

DEDUCTIBLE ADJUSTMENT REQUEST

TO: Program/Region Mgr _____ (MS#_____) Date_____
FROM: _____ Title _____ (MS#) _____

RE: _____F/P #_____ MR # _____
Patient Name

CRITERIA: (Check those applicable for Deductible Adjustment)
_____ Stated inability to pay due to_____

UMDAP Annual Deductible $_____Monthly Rate $ _____ Contract Yr _____

_____ Without treatment, patient may become suicidal and/or injure self or others.
_____ Recommended by Therapist that reduction be granted. Therapist _____
Signature

Amount Patient will pay: Annual $ _____ Monthly $ _____
STATEMENT: (Further justification) _____
_____
_____
_____
_____

Continue on attached sheet if necessary

Eligibility Recommendation (If Needed): ☐ **APPROVAL** ☐ **DISAPPROVAL** ☐ **NO RECOMMENDATION**
_____
_____

Signed _____

Adjustment Review: ☐ Disapproved
☐ Approved For

Annual Deductible $ _____

_____
Program/Region Mgr. Signature

Payable Monthly at $ _____
To &
Route cc: Eligibility Review (S-22 (G)

☐ Request Unjustified – Denied ☐ Request Justified Reduce To
Final and/or
Appeal Review:

ADMINISTRATOR _____ ANNUAL $ _____ MONTHLY AT $ _____

HHSA:MHS-661 (2/2005)

Route to (4) & cc: Eligibility Review S-22 (G)

SERVICE DELETION REQUEST FORM

UBH Service Deletion Request

Reporting Unit ____________________ Date __________________ Requested by________________________

Client Number	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
					1			
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		
					1			
Client	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
					1			
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		
Client	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		
Client	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		
Client	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		
Client	Service Date	Procedure Code	Therapist	Time HH:MM	Units of Service	Service Cost	Reason for Deletion	*Billed To
	Date Keyed	Correct Proc. Code	Therapist	Time HH:MM	Units of Service	Service Cost		

*NOTE: “Billed To” column to be completed by UBH Finance Staff

Request for Insurance Company Addition

San Diego County Organizational Providers

Insurance Company Name: _____

Street Address 1: _____

Street Address 2: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____

Telephone Number: ( ) _____

Requested By: _____ Tel. No.: _____

Please fax this request to:

Anselma Danque
(619) 641-6975 (Fax)

Should you have any questions, please contact Anselma directly at (619) 641-6849. You will be notified as soon as the insurance policy is inserted.

Date: _____
Time: _____
Person Notified: _____

Collection of Client Accounts
Program Name: _____
Reporting Unit _____

San Diego County Organizational Providers
Client Payment Record
Date_____

	Account #	Client Name	Date Received:	Date Sent to UBH:	Amount:	Check #/Money Order
1.					$	
2.					$	
3.					$	
4.					$	
5.					$	
6.					$	
7.					$	
8.					$	
9.					$	
10.					$	
11.					$	
12.					$	
13.					$	
14.					$	
15.					$	
16.					$	
17.					$	
18.					$	
19.					$	
20.					$	

San Diego County Organizational Providers

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
EFFECTIVE OCTOBER 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA**				
0-569	37	33	30	27	24
570-599	40	36	32	29	26
600-649	45	40	36	32	29
650-699	50	45	41	37	33
700-749	56	50	45	41	37
750-799	63	57	51	46	41
800-849	71	64	58	52	47
850-899	79	71	64	58	52
900-949	89	80	72	65	59
950-999	99	90	80	72	65
1000-1049	111	100	90	81	73
1050-1099	125	112	101	91	82
1100-1149	140	126	113	102	92
1150-1199	156	140	126	113	102
1200-1249	177	159	143	129	116
1250-1299	200	180	162	146	131
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549-	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456
$ 4200 and above add $ 400 for each $ 100 additional income					

- *Monthly Gross Income after adjustments for allowable expenses and asset determination from computation made on the financial intake form.
- ** Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements.
- Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code. (ATTACHMENT C)

10/20/89

MEDI-CAL ELIGIBILITY

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU				
	1. $ 602	3. $ 934	6. $ 1,417	9. $ 1,825
	2. $ 750	4. $ 1,100	7. $ 1,550	10. $ 1,959
	2. $ 934 (Adults)	5. $ 1,259	8. $ 1,692	

Asset allowances for 1989 are:

Persons			
	1. $ 2000	4. $ 3300	7. $ 3750
	2. $ 3000	5. $ 3450	8. $ 3900
	3. $ 3150	6. $ 3600	9. $ 4050

Aid categories commonly found in community mental health are:

REFUGEE- First 18 months in the U.S.	**DISABLED**- Meeting Federal definition of disability.
AGED- 65 years of age and over	**AFDC**- Aid to Family with Dependent Children.

MEDI-CAL SHARE-OF-COST

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-years of age man would be eligible for Medi-Cal except his income is too high. He has a $ 1,000 medical bill. He meet low asset levels, but his income from retirement is $1,000 per month. His income is $ 1,000 minus the standard $20 disregard and the $ 24.90 payment for the Medicare Part B, leaving a "net" of $ 955.10. His "share-of-cost" for Medi-Cal is $ 955.10 minus $ 602 ("need level") or $ 353.10. Medi-Cal will pay the remainder of the $ 1,000 medical bill for that month and other months when he obligates the share-of-cost above $ 353.10. His eligibility will be re-determined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or incomes in the shaded area don not have an annual deductible.

Medi-Cal Information Numbers:

Medi-Cal Mail-In Applications & Info. Public Assistance Unit	1-866-262-9881
San Diego Kids Health Assurance Network (SDKHAN)	1-800-675-2229
Healthy Families	1-800-880-5305
Healthy-e-App	1-866-861-3443

Family Resource Centers that take Medi-Cal Applications:

Family Resource Center – Southeast
4588 Market St.
San Diego CA 92102; (619) 236-7501

Family Resource Center – Northeast
5001 73rd St.
San Diego CA 92115; (619) 464-5701

Family Resource Center – North Coastal
1315 Union Plaza Ct.
Oceanside CA 92054; (760) 754-5757

Family Resource Center – North Inland
620 East Valley Pkwy.
Escondido CA 92025; (760) 741-4391

Family Resource Center – Lemon Grove
7065 Broadway
Lemon Grove CA 91945; (619) 464-5114

Family Resource Center – Kearny Mesa
5201 Ruffin Rd.
San Diego CA 92123; (858) 565-5598

Family Resource Center – El Cajon
220 S. 1st St.
El Cajon CA 92021; (619) 579-4335

Mills Building/Trolley Towers
1255 Imperial Ave.
San Diego CA 92101; (619) 338-2555

South Region Center
690 Oxford St.
Chula Vista CA 91911; (619) 427-9660

Fallbrook Community Resource Center
130 E. Alvarado St.
Fallbrook CA 92028; (760) 723-5681

Ramona Community Resource Center
1521 Main St.
Ramona CA 92065; (760) 738-2438

Family Resource Center – Mission Valley
7947 Mission Center Ct.
(Granted Cases Only)
San Diego CA 92108; (619) 767-5206

SSI Advocacy Services for Mental Health Clients:

Casa Del Sol Clubhouse
1157 30th St.
San Diego CA 92154; (619) 429-5205

Mariposa Clubhouse
560 Greenbrier, Suite 102
Oceanside CA 92054; (760) 439-6006

Episcopal Community Service
1009 G St.
San Diego CA 92101; (619) 238-8201

The Meeting Place
4034 Park Ave.
San Diego CA 92103; (619) 294-9582